

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/20/2014
NAME OF PROVIDER OR SUPPLIER ALLISONVILLE MEADOWS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 10420 ALLISONVILLE ROAD FISHERS, IN 46038		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for an Initial State Residential Licensure Survey.</p> <p>Survey dates: January 17 and 20, 2014</p> <p>Facility number: 013039</p> <p>Survey team: Michelle Carter, RN</p> <p>Census bed type: Residential- 52 Total- 52</p> <p>Census payor type: Other- 52 Total- 52</p> <p>Sample- 10</p> <p>Allisonville Meadows Assisted Living was found to be in compliance with 410 IAC 16.2 in regard to the Initial State Residential Licensure Survey.</p> <p>Quality Review 01/21/14 by Lisa McColly</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE